STATE OF CALIFORNIA GRAY DAVIS, Governor

Board of Chiropractic Examiners
2525 Natomas Park Drive, Suite 260
Sacramento, California 95833-2931
Telephone (916) 263-5355 FAX (916) 263-5369
CA Relay Service TT/TDD (800) 735-2929
Consumer Complaint Hotline (866) 543-1311
http://www.chiro.ca.gov

Consumer Complaint Form

Please Print or Type *Please provide all the requested information.*

COMPLAINT REGISTERED AGAINST				
Name of Chiropractor:			Phone: (area code)	
Practice Name:				
Practice Address:	City:	County	State:	Zip Code:

PERSON REGISTERING COMPLAINT			
Name of Person Registering Complaint:		Work Phone: (area code)	
Address:		Home Phone: (area code)	
City:	County:	State:	Zip Code:
Have you complained to any other organization? (Please specify)			

DETAILS OF THE COMPLAINT	
Type of Illness or Injury/Reason for Appointment:	Date of Visit(s):

State your complaint in detail:

Attach additional sheets if necessary.

NOTICE: Except for the name of the chiropractor, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. As much information as possible should be provided in connection with the complaint. The information on this form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to other governmental agencies, including the Attorney General's Office.

Signature _____ Date _____

*** SEE REVERSE SIDE ***

Board of Chiropractic Examiners

AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

I, the undersigned hereby authorize:

Chiropractor _____ Chiropractor _____

Facility _____ Facility _____

Address _____ Address _____

_____ _____

Phone Number _____ Phone Number _____

Chiropractor _____ Chiropractor _____

Facility _____ Facility _____

Address _____ Address _____

_____ _____

Phone Number _____ Phone Number _____

to disclose records in the course of my diagnosis and treatment, including medical, psychiatric, alcohol and drug abuse records to the **BOARD OF CHIROPRACTIC EXAMINERS, ENFORCEMENT PROGRAM**. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid until the Board of Chiropractic Examiners of the State of California completes its investigation and proceedings arising out of the complaint and/or investigation.

A copy of this authorization shall be as valid as the original. I understand that I have a right to receive a copy of this authorization upon my request.

Signature: _____ _____

Patient Date

Or: _____ _____ _____

Legal Representative Relationship Date

Rev. 10/99